Washington State Department of Health
Washington State Board of Pharmacy
PO BOX 1099
Olympia, WA 98507-1099
360.236.4700

Application for Disability (ADA) Accommodation Pharmacy Licensing Examinations

Instructions

You must submit an Application for Disability Accommodation to request accommodations for taking the North American Pharmacist Licensure Examination (NAPLEX) and Washington State law examination (MPJE).

The Americans with Disabilities Act (ADA) requires us to provide reasonable accommodations to qualified individuals with disabilities. Disabilities are physical or mental impairments limiting one or more of a person's major life activities. This includes walking, hearing, speaking, seeing, reading, or writing.

We will review your request. If granted, the Board of Pharmacy will forward the approval to the National Association of Boards of Pharmacy (NABP).

We will keep your request on file for one year. It will be valid for any examination taking place within the one-year period. You must complete a new form if your disability status or requested accommodation changes.

Application for Disability Accommodation
Pharmacy Licensing Examinations

PART I: APPLICANT'S STATEMENT

Name: _____

Address: _____

_____

Social Security Number: _____

Telephone Number: _____

Birth date: _____

Examination: NAPLEX _____ MPJE _____

Description of disability and how it impacts taking examinations: _____

_____

Physician, Therapist, or Other Health Care Practitioner: (List additional practitioners on a separate sheet of paper and attach to this form.)

Name: _____

Office Address: _____

Telephone Number: _____

Length of Time as Patient: _____

Type of Accommodation(s) Requested: _____

If you have previously been provided with test accommodation(s), please list the provider and describe the accommodation(s): _____
_____

RELEASE

I authorize the practitioner(s) listed above to release to the Board of Pharmacy or its legal representative any and all information in his or her possession about my disability described above. "Information" means all information in the possession of, or derived from, providers of health care regarding my medical history, mental or physical condition, or treatment. I agree that this authorization shall be valid until canceled in writing by me. I understand that the Board of Pharmacy will use the information obtained by this authorization to determine eligibility for a reasonable accommodation with regard to the pharmacist licensure examination by reason of my disability. The Board reserves the right to require additional information or documentation to support this request for accommodation. The Board will not release any information obtained to any person or organization, except to NABP (the test developer), or any government agency that may be involved with my application to take the pharmacist licensure examination. Under penalties of perjury, I declare that the foregoing statements and those in any accompanying documents or statement are true. I understand that false information may be cause for denial or loss of a license. I hereby certify that I personally completed this application and that I may be asked to verify the above information at any time.

Signature: _____ Date: _____

Subscribed and sworn to before me this _____ day _____ 20_____

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PART II: PRACTITIONER'S STATEMENT

Practitioner Name: _____

Professional Title: _____

Office Address: _____

Telephone Number: _____

State License Number: _____
(if applicable)

Patient's Name: _____

Patient's Address :_____

Patient's Social
Security Number: _____

Date Patient
First Consulted: _____

Date Patient Last Seen: _____

Diagnosis of Disability and Basis for Diagnosis: _____

_____

_____

Recommended Accommodation(s): _____

_____

_____

CERTIFICATION

I hereby certify that the above information is true and is provided pursuant to the authorization to release information by my patient. I also certify that I have the necessary specialized training to make the above diagnosis, that I personally examined the individual named above, and that the above diagnosis and assessment of the accommodation request is my professional judgment. I understand that the Board of Pharmacy may contact me (with the applicant's permission) to obtain further information if necessary, and that the Board may obtain an independent assessment by another professional.

Practitioner's Signature: _____ Date: _____